Written comments submitted to the Department of Health Care Services (DHCS)
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS,
effective July 1, 2012

Comments received September 10 to September 21, 2011

Note: In some cases, DHCS has edited the responses to explain the acronym used by the writer, or to remove personally-identifying information; spelling, grammar, and punctuation have not been edited. Specific references to the writer's organization have not been removed.

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The California Alliance of Child and Family Services is a statewide association of 120 accredited, private nonprofit human service agencies that provide a wide array of services to children, youth, transition-age youth, and families, including the full continuum of mental health services and support. California Alliance member agencies work in collaboration with county public mental health departments, child welfare and juvenile justice agencies, and local school districts across the state.

1. It is imperative that a Children's Mental Health Policy Office be included in the transition plan for the transfer of Medi-Cal Specialty Mental Health Services from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS).

   The draft transition plan currently lacks specificity on where children's mental health policy will exist within DHCS. The policy section of the transition plan discusses waiver renewal, state plan and regulations but it isn't clear where children's policy issues will be addressed. Specificity regarding where and who will develop children's policy is necessary because of the unique federal requirements, provider specialization, and treatment methodologies, all of which require policies, procedures and regulations different from those for adult mental health care.

   For the past 18 years, statewide changes in mental health services for California children have been the result of lawsuits (e.g., *Timothy T.*, *Emily Q*. and *Katie A.)*, not policy initiated at the state level. In order to avoid this pattern, we are hopeful that DHCS will take a pro-active approach to children's mental health policy to ensure that children have access to effective, culturally appropriate services delivered in the least restrictive setting that meets their needs.

2. The lawsuit compliance group charged with implementation of the settlements in the *Emily Q.* and *Katie A.* suits should remain intact for the transition. They are responsible for working with the court appointed special master and vested parties. Ultimately this group is responsible for implementation of all aspects of the settlement including but not limited to the development of manuals, educating and training counties, and tracking data to ensure delivery.

3. **It is imperative that the DMH Legal Department be moved into the Mental Health Division/Office** to ensure staff familiar with Mental Health and parity issues be available to address Medi-Cal mental health litigation, policy manuals and issues.

4. In order to help identify and assure that contracted providers of children's mental health services have the necessary expertise and administrative infrastructure to meet Medi-Cal requirements, DHCS should require that provider organizations be certified by a recognized accrediting body, such as the Council on Accreditation, the Joint Commission or the California Alliance. Accreditation provides public notification that an agency meets the standards of

quality set forth by an accrediting body and reflects the fact that the agency has conducted a self-study and undergone external review by knowledgeable experts, not only to meet standards, but to continuously find ways to improve the quality of the programs and services it provides. If we would not send our children to unaccredited schools or have them treated in unaccredited hospitals, why would we permit unaccredited organizations to provide mental health services for the state's most vulnerable children?

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Gov. Brown Launches Health Reorganization: What is MHSA Fix?

For every Mental Health Services Act (MHSA) success story published, there are countless unpublished stories of tragedy, neglect, incarceration, hospitalization, and failed institutions—stories of unending struggle by consumers to gain independence, families torn apart, exhausted and impoverished by a lifetime of seeking healing treatment for serious mental illnesses, and devastated by the ultimate failure, when despair leads to death by suicide. We believe evaluations of MHSA to date are not designed as relevant to system conditions or progress. California Mental Health Directors Association (CMHDA) Recommendations of September 2011 are a path to equitable systems and wise use of every possible resource. Active community stakeholders can gain the tools to fight for integration, access, and quality services.

Background Facts: MHSA law: 75% of revenue allocated to expand services and raise standards in existing county Systems of Care, 20% for new prevention programs chiefly to prevent mental illness from becoming severe or disabling. Access to Services: Records indicate 600,000 people sought services in public mental health in 2009, while DMH reports 423,000 are currently served; the reduced population served is not due to recovery. Quality of Care: In 2005-06 counties using DMH definitions reported 95-100% of consumers were *"underserved or inappropriately served"* and 0-5% of clients were "fully served." After $7 Billion in MHSA funds since 2004, the state and counties report less than 5% of consumers are "fully served" in 2010. This is not a successful "Bang for the Buck" story by any measure.

Define the Problem. The "big picture" consequences of implementation/funding policies are:

- Department of Mental Health (DMH) regulations deny MHSA benefits to 90% of consumers, poorly served in substandard, bottom-tier county systems, existing before and after Prop 63;
- DMH "Disinformation" campaign targeting MHSA revenue to new programs for new clients is a costly, inequitable experiment, which created a two-tier system;
- DMH and OAC policies discourage integration of MHSA and Systems of Care, and instead fund new, top-tier programs for a select few consumers in independent systems, absent knowledge of existing county programs, system gaps, and fragmentation;
- Prevention "principles and priorities" of the Oversight and Accountability Commission (OAC) do not serve MHSA target populations, and allow funds to be diverted for social programs unrelated to serious mental illness;
- DMH and OAC fail to provide counties and all stakeholders with proper tools and operating guidelines regarding purpose, ethics, parameters, or expectations for improvements in "Systems of Care," resulting in widespread waste, misunderstanding of law, and complaints of state and local conflicts of interest.

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Protect Prop 63—Fix MHSA

- Modify DMH regulations which are inconsistent with MHSA law passed in 2004 and inconsistent with amendments enacted under Governor Jerry Brown in 2011;
- Seek update on clients in public mental health that are "Underserved/Inappropriately served" and develop system baseline in each county to report authentic evaluations;
- Eliminate three arbitrary categories of Systems of Care funding, which facilitate two-tier system, prohibit integration, and violate contract with voters who enacted law in 2004.
- Develop new OAC/DMH Prevention guidelines to properly target funding for at risk prevention and early intervention (PEI) populations defined by MHSA.
- Streamline, organize, and maximize benefits of stakeholder participation under Department of Health Care Services (DHCS)/DMH leadership by consolidating MHSOAC and Planning Council functions, establishing collaborative relationships with CMHDA and County Mental Health Boards and Commissions, and conducting a state public information campaign to ensure a shared understanding of MHSA purpose so that all policymakers, stakeholders, and counties act on standardized guidelines to benefit all consumers. Maximize expertise and investments in evaluation and performance reports through MHSA provisions which designate OAC Commissioners as members of Planning Council. A unified OAC/Planning Council could take the lead to end fragmented governance, ensure access to tools for effective participation, and build credibility for stakeholder process.

Create Efficiency, Compliance, and Accountability with Integration

The State's early direction was not rooted in the law, and defied years of research and knowledge of programs actually in demand by consumers. New MHSA start-ups are an inefficient experiment. A direct course correction is now required for all of those clients who have been poorly served or inappropriately served, including those in Full Service Partnerships (an ill-advised, stand-alone service category). Counties need state support and guidance to integrate all mental health funding categories, and facilitate Systems of Care improvements—this means integration of ALL service delivery systems and clinics who serve those with serious mental illnesses. Evaluations should measure access to all Medicaid-funded programs and a BASELINE should use Systems of Care codes as standard. Reorganization must serve goals of full integration of all health services, achieve parity, and maximize federal health reform benefits.